Articles

Tort Reform and the Obstetric Access Crisis
The Case of the WAMI States

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The states of Washington, Alaska, Montana, and Idaho (WAMI) have all had declines in the proportion of physicians offering obstetric services during the past few years, a decline precipitated by rising medical malpractice premiums. One response to the problem of rising liability premiums has been the passage of extensive tort reform legislation. We present the results of recent studies of physicians' obstetric practices in the WAMI states and summarize the major changes in tort legislation and regulation that have occurred in these states.

Most general and family physicians in the WAMI region no longer provide obstetric care; by contrast, more than 80% of the obstetrician-gynecologists in the WAMI states are still practicing obstetrics. Despite the fact that only a minority of family physicians are still active in obstetrics, most rural family physicians in all four states still deliver babies. Most physicians in all four states limit the amount of care they provide to those covered by Medicaid, which suggests that significant barriers to care exist for medically indigent persons.

All four states have adopted significant tort reforms. Despite these changes in the legal environment, the cost of malpractice premiums and concerns over the likelihood of being sued continue to limit the number of physicians willing to provide obstetric care. Although it cannot be inferred from these data that tort reform has decreased the rate at which physicians give up obstetric practice, the evidence is compatible with such a conclusion.

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Obstetrics has been one of the aspects of medical practice most affected by provider responses to changes in the medical malpractice environment. During the 1980s, thousands of providers stopped practicing obstetrics or severely limited the scope of their practices, most frequently citing their concerns about medical malpractice as the reason for these changes in their obstetric practices.[1-5] Two groups have been severely affected by these changes in practice patterns: poor women who cannot afford to purchase care in the private market and women living in rural areas where obstetric care has become unavailable.[6-8] Problems of access to obstetric care have become major challenges to state government in all the states of the Pacific Northwest.

Washington, Alaska, Montana, and Idaho (the WAMI states) are large western states with dispersed rural populations. Each of these states has experienced an exodus of obstetric providers, with a major cause being identified as the obstetric malpractice crisis.[9-11] Although the prevailing tort laws have an effect on a wide variety of persons and organizations—from the school raising funds by hosting a summer carnival to the municipality trying to insure its swimming pool—the effect on obstetric care has been both poignant and highly visible.

As in most other states in the country, the four WAMI states instituted a series of legislative reforms at least partly motivated by the desire to restore the availability of obstetric care to rural populations. Although these legislative changes had much wider import than just their effect on obstetricians, family physicians, and midwives, the professional groups that provide virtually all obstetric care, the behavior of these groups may serve as an indicator of the efficacy of the tort changes. Because each state adopts its own legislative approach to tort reform, it may also be possible to determine the relative efficacy of these approaches by looking at end points such as the proportion of eligible practitioners who continue to practice obstetrics.

This study is a descriptive attempt to do such an analysis in the four WAMI states. We compare recent survey data about obstetric practice patterns of physicians in each state and juxtapose these findings with the major legislative reforms in tort law that have occurred over the past 20 years.

Methods

Legislation on Medical Malpractice

The legislative response to the malpractice crises of the 1970s and 1980s spanned three separate areas of law and regulation: reforms of the professional liability insurance industry, reforms aimed at improving the quality of medical care, and reforms of the tort system itself.[12] These legislative interventions were extremely diverse; they included such measures as the establishment of joint underwriting associations, designed to make malpractice insurance available, and limits on the amount of damages that could be awarded in cases where physicians or others were found to be negligent.

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TABLE 1.—*The Major Legal Reforms of the 1970s and 1980s**

- Insurance Reforms
  - Joint underwriting associations
  - Limits on insurance cancellation
  - Mandates for liability coverage
  - Patient compensation funds
  - Reporting requirements
- Reforms Aimed at Medical Quality
  - Peer review requirements, protection from lawsuits
  - Increased powers of disciplinary boards
  - Reporting requirements, data compilation
  - Requirements for continuing medical education
- Tort Reforms
  - Aimed at the number of lawsuits (insurance frequency)
    - Arbitration
    - Attorney fee controls
    - Certificate of merit
    - Costs awardable
    - Pretrial screening panels
    - Statutes of limitations
  - Aimed at size of recoveries (insurance severity)
    - *Ad damnums* restricted
    - Caps on awards (noneconomic, total)
    - Collateral source offset (permissive, mandatory)
    - Joint and several liability changes
    - Periodic payments of damages (structured awards)
    - Punitive damage limits
  - Aimed at plaintiffs' difficulty (or costs) of winning
    - Expert witness requirements
    - Informed consent limits
    - Professional standard of care reasserted
    - *Res ipsa loquitur* restrictions
    - Statute of frauds for medical promises
  - Aimed at functioning, cost of judicial process
    - Mediation
    - Notice of intent to sue
    - Precalendar conference required
    - Preferred scheduling for malpractice cases
  - Miscellaneous
    - Extension of "Good Samaritan" statutes
    - Immunity for school athletic injuries
    - All other

*Adapted from Bovbjerg.[13]

To analyze these changes, we used categories developed as part of a national study of medical malpractice insurance (Table 1).[13]

Our research draws on this comprehensive review of the legislative record. Each legislative enactment for the four WAMI states was reviewed and characterized according to category. This statutory compilation was cross-checked against other listings distributed by trade associations and other sources. Because the original national survey of tort reform on which this article draws was concluded in 1987, more recent legislative enactments were documented by calling medical associations in the WAMI states. Any subsequent judicial invalidations or modifications of the original statues are also noted, as well as any termination of legislation in the case of predetermined "sunset" language in the original bills.

Obstetric Practice Patterns of WAMI Providers

Data on the obstetric activities of physicians in the four WAMI states were obtained from surveys of practicing physicians. In all four states, periodic surveys were initiated in the mid-1980s when it became apparent that a substantial number of physicians were deciding to discontinue obstetric practice. In each state, a different group was responsible for the survey. The sources of the survey material are summarized briefly on a state-by-state basis.

Washington. The Washington data are based on a 1989 survey of all potential obstetric care professionals in the state, including obstetricians, general and family physicians, and nurse midwives.[14] The data in this article are based on the responses of 1,407 physicians, representing a 73% response rate.

Alaska. The Alaska data come from two surveys conducted by the Department of Health and Social Services of the State of Alaska. The first questionnaire, which concentrated on the availability of obstetric care to low-income women, was sent to all potential obstetric care professionals in the summer of 1988 and had a 93% response rate (182 of the 196 physicians surveyed). These data were supplemented by a February 1989 survey that focused specifically on problems relating to medical liability.

Montana. The Montana data come from a 1988 survey of all Montana physician providers conducted by the Montana Academy of Family Practice. This was the most recent of a series of surveys conducted annually since 1985, when the obstetric care availability crisis was first noticed in Montana.

Idaho. The Idaho data are based on a survey administered jointly by the WAMI Rural Health Research Center and the Idaho Medical Association. The survey technique was identical to that used in the Washington study, and the questionnaire was mailed in the summer of 1989. There was a 77% response rate, with 303 physicians responding.

Analysis of Surveys

Because the surveys were undertaken by different groups, the data collected across the four states are not directly comparable. An attempt was made to ensure comparability of two key variables: differences between rural and urban provision of care and the relative propensity of physicians to provide obstetric care for medically indigent women. Differences in survey design, however, make it impossible to be sure that the categories were exactly equivalent.

The designation of rural and urban places was difficult, both because the existing federal definitions have limitations and because the concept of "rural" differs from one state to another. Although our final distinction was somewhat arbitrary, we tried to use categories that were meaningful in terms of the provision of medical care.

In Washington State, a county was considered rural if 50% or fewer of the inhabitants lived in an urban area as defined by the US Bureau of the Census; urban counties were those in which more than 50% of the inhabitants lived in urbanized areas. Thus, 19 counties were urban and 20 were rural.

In Alaska, physicians living in the Anchorage metropolitan area were considered to be urban; the rest of the state was classified as rural. In Montana, Billings and Cascade (Great Falls) counties were categorized as urban, and the rest of the counties were termed rural. In Idaho, only Ada County (Boise) was considered urban, and the rest of the state was considered rural. This recognizes the fact that, with the exception of Washington, there are few truly urban areas in the WAMI states.

Results

In the tables that follow, information was not uniformly available for all states or across all categories. Only data that were felt to be comparable are shown in the tables.

Table 2 displays the medical malpractice legislation enacted in the four WAMI states between 1955 and 1989. The

pattern in the WAMI states is similar to that which prevailed across the nation. Legislators in all four states selected from a variety of options, enacting a diverse array of legislation over more than three decades covered in this review. Statutory interventions covered all three major areas of reform: insurance, quality review, and alterations in tort law.

It is worth commenting briefly on each of these three broad areas to compare the case of the WAMI states with the national experience.

Reforms of Insurance

The WAMI states were similar to most other states in establishing legislation that permitted joint underwriting associations. A major response to the insurance availability crisis of the 1970s, joint underwriting associations established a mechanism whereby states could guarantee that most physicians could purchase insurance. Despite their statutory approval, only in Alaska did a state-sponsored insurance mechanism become the dominant malpractice insurer. Washington resembles many other states in its creation of a physician-sponsored medical malpractice insurance company that dominates the local market; 55% to 60% of all American physicians are now insured by such companies.[11]

The WAMI states differ from other states in that none of them limited the ability of insurance companies to cancel insurance coverage or established patient compensation funds. In all four states, the most important response to the lack of availability of insurance was to create mechanisms by which insurance coverage could be made available through nontraditional insurers.

Reforms Aimed at Medical Quality

The WAMI states directly mirrored the national experience in providing reforms aimed at medical quality. All four states enacted legislation protecting the peer review process, greatly increased the power of professional disciplinary boards, and expanded reporting requirements designed to record information about any disciplinary action taken against physicians. With one exception—the new reporting requirement in Washington—all of these legislative mandates occurred before 1980 and were unconnected with the crisis of insurance affordability that dominated the 1980s.

Reforms of Tort Law

All four states enacted legislation in the 1980s that sought to modify existing tort law. Although it is impossible in the space available to comment on all the elements of each state's laws, several approaches were common to most of the WAMI states.

Pretrial screening panels were enacted during the 1970s in all the states except Washington. Because these panels did not prevent the subsequent problem of malpractice insurance affordability, it might be reasonably concluded that this mechanism did not have much effect on the number or size of suits brought against physicians. By the same token, statutes of limitation were made narrower in all four states during the 1970s, although the Washington limitation was made even more restrictive with enactment of a major tort reform package in 1986. Again, the actual monetary consequence of this modification appears to have been minor.

The most far-reaching tort modifications were designed to limit the amount of recoveries. All four states instituted "strong" tort reform in the 1980s, with the core of each being a series of interrelated measures whose major effect was expected to be a decrease in the ultimate size of awards.

All four states restricted the use of *ad damnums,* the practice in which plaintiffs list the particular amount of award sought in the initial legal pleading. A much more important reform was a cap on awards, which was enacted in all of the states except Montana. This cap was subsequently struck down as unconstitutional by the Washington State Supreme Court in the case of *Sophie v Fibreboard,* thus removing one of the central pillars of the 1986 Washington State tort reform package. The cap was substantially weakened in Alaska where an exception was allowed for plaintiffs who suffered significant physical impairment. All four states also enacted changes in the doctrine of joint and several liability, thus eliminating to some extent the plaintiff's ability to recover disproportionately from "deep pockets" in cases of injury.

Two other tort reforms completed the package: arrangement for the periodic payment of damages and limitations on the amount of punitive damage. The first was instituted in all states except Montana, with limits on punitive damages introduced in all states but Washington. To date, these provisions still stand in each state where they were enacted. Although various other changes have been enacted, none of them are as pervasive or far-reaching as the ones mentioned.

The major finding illustrated in Table 2 is that the WAMI states, like their national counterparts, had two distinct periods of legislative activism with regard to medical malpractice legislation. The first took place during the 1970s in response to the problem of insurance availability; it was designed to make it easier for alternative insurance arrangements to be established and tightened up the surveillance of physicians but, for the most part, avoided meaningful reform of the tort process. The second wave occurred in 1986 and 1987 in response to skyrocketing medical malpractice insurance premiums, which translated into decreased availability of physician services and coincided with the barriers faced by many other private and public organizations in buying liability insurance to cover themselves against routine acts and services. This second wave focused on relatively strong measures, the intent of which was to make it more difficult to sue and recover large awards. All four of the WAMI states selected from the same package of reforms, and; with the exception of the Washington State caps, those reforms enacted are still operational.

Obstetric Practice Patterns

The obstetric access crisis of the late 1980s was triggered by the decision of many family physicians to discontinue obstetric practice. Although family practitioners deliver fewer babies in the aggregate than their obstetrician colleagues, approximately three times as many family physicians practice obstetrics as do obstetricians in the four WAMI states. In addition, for many of the rural communities in the northwestern states, family physicians are the only local source of obstetric care. Thus, the decision of large numbers of individual practitioners to stop delivering babies had an immediate effect on one of the basic health services taken for granted in many smaller communities.

Table 3 shows the current status of obstetric practice in all four states. The proportion of family physicians actively involved in obstetrics at the time of the surveys ranges from 53% in Idaho to 37% in Alaska. By contrast, a large majority

TABLE 2.—*Selected Changes in Tort-Related Legislation by WAMI State, 1955 to 1989*

Type of Enactment	*Washington*	*Alaska*	*Montana*	*Idaho*
Reforms of Insurance				
Joint underwriting associations (JUAs)	None; but insurance commissioner mandated to study effectiveness of JUAs (1986)	Medical Indemnity Corp of Alaska created (1976); in 1989, it insured 60% of all physicians and all but 2 rural hospitals in state	Montana Insurance Assistance Plan created (1977); 1979 amendment extended life of program to 1981; 1985 enactment provided for expiration in October 1991; JUA is on standby status	Hospital mutual or trust allowed; JUA created on standby status (1977); amended 1975 to no later than 1980; amended 1979 to no later than 1982
Mandates for liability coverage	Health care coverage subject to authority of state insurance commissioner; guidelines for assessing impact of mandatorily offered health coverage (1984)			
Reporting requirements, insurance cancellation limits			Insurers must report to insurance commissioner number of insureds, premiums paid, number and amount of claims made, lawsuits filed, settled, and pending, judgments rendered; no cancellation allowed based on claim for damages determined to be unfounded and no payment made by insurer (1971)	Before cancelling policy, must notify insureds 60 days in advance (1987)
Reforms Aimed at Medical Quality				
Peer review requirements, protection from lawsuits	Immunity from civil suit arising from duties on professional review committees (1969, amended 1976, 1985)	Peer review immunity unless information false and known to be false (1976)	Immune from liability for actions taken within scope of functions of committee if without malice; proceedings not discoverable or admissible into evidence in any other proceeding unless otherwise admissible (1975, 1977)	In-hospital staff committee and medical society: all records confidential and privileged; no civil liability for furnishing information or opinions to such committee; exception permits limited disclosure of information to malpractice claimant (1973)
Powers of disciplinary boards increased	Board given power to investigate charges of malpractice (1975); given additional staff (1979); medical discipline account in state treasury created (1983) (statute enacted 1955; amended 1975, 1979, 1982)	Board may impose sanctions for extensive list of violations: false advertising, demonstrated unfitness, unprofessional conduct, denied care if patient refuses to arbitrate, has lost license in another state, secured license through deceit (1974, amended 1983)	State Board of Medical Examiners has power to discipline physicians; amendment in 1975 added suspension or revocation of license in another jurisdiction to grounds for disciplinary action (1969; amended 1975, 1977, 1979)	Board of Professional Discipline can fire employees, promulgate rules and regulations, compel production of physicians and testimony of witnesses, control physician licensure, and has budgetary authority (1977)
New reporting requirements	Licensed health care professionals are required to report to Medical Disciplinary Board when they have personal knowledge that practicing physician has committed an act of unprofessional conduct (1986)	Hospitals required to report denial of staff privileges; doctors report treatment for alcohol or drug abuse or mental illness posing danger to public (1974)	Physicians must report incompetence or unprofessional conduct; physician's insurer must report any claim of professional negligence and disposition of claim to State Board of Medical Examiners; hospitals must report changes in staff privileges (1977)	Hospital must report changes in hospital staff privileges, any disciplinary action taken against physician (1976)
Requirements for continuing medical education	Washington State Board of Medical Examiners created, 1961 (1955 legislature); power to demand continuing medical education (1971)	Continuing medical education mandated as prescribed by regulation, no less than 15 hours in 5 years (1976)		
Risk management		For licensing, hospital must have internal program to investigate frequency and causes of malpractice incidents, develop and implement measures to reduce risks of injury to patients, and analyze patient grievances relating to patient care (1976)		
Tort Reforms Aimed at Number ("Frequency") of Lawsuits				
Arbitration		Arbitration framework; both before- and after-injury arbitration allowed (1967; amended 1976, 1978)		
Attorney fee controls	Court review of reasonableness of attorney fees required (1976)	Attorney fees may only be awarded if action is contested without trial or fully contested as determined by the court (1962, amended 1986)		Limited to 40% of value recoverable, court review of fees' reasonableness required in all malpractice cases (1975)
Costs awardable		1962 statute does not specify which costs are awardable; attorney fees awardable if action is contested without trial or is fully contested, as determined by court (1986)		

Pretrial screening panels		Expert advisory panel appointed by court in all malpractice actions (if deemed necessary for expertise); panel's report is discoverable and admissible as evidence; if ruled that party made a frivolous claim or defense, that party pays all expert panel's costs (1976)	Pretrial screening panel mandated unless claim is subject to a valid arbitration agreement; panel investigates whether claim merits a trial; decision is not binding (1977)	Pretrial screening compulsory, privileged, and immune from civil process; no record kept of proceedings, evidence is returned at end; has subpoena power; unanimous decision on damage amount may be told to parties, insurers, and other third-party payers; panel decision not appealable; panel members not paid, 90-day hearing limit (1976)
Statutes of limitation	Malpractice action must be brought within 3 years of negligence or 1 year of discovery, in no event longer than 8 years from the act (1971; amended 1976, 1986)	Basic tort/personal injury statute of limitation of 2 years (1962)	Malpractice action must be brought within 3 years of injury or discovery, with maximum of 5 years (1971)	Action must be brought within 2 years following injury or 1 year after discovery (1970); 1971 amendment to generic statute of limitations added provision that for medical or professional malpractice before 1971, generic law was applicable
Aimed at Size ("Severity") of Recoveries				
Ad damnums restricted	*Ad damnum* clause 4.28.360	Lawsuits can plead only that damages demanded are within jurisdiction of court (1976)	No dollar amount allowed in pleadings (1977)	Grounds for mistrial if any person discloses amount of general damages sued for to the jury (1976)
Caps on awards (noneconomic, total)	Limitation on noneconomic damages (1986); struck down as unconstitutional (1989)	Limit of $500,000 per separate incident for personal injury based on negligence (1986); plaintiffs with physical impairment or disfigurement excepted		$400,000 cap on noneconomic losses (1987)
Collateral source rule		Evidence of collateral sources is admissible after fact finder has rendered an award; claimant can only receive damages in excess of amounts received as compensation for injuries from collateral sources (1976)	Plaintiff allowed to introduce premium payments (1987)	Damages limited to compensatory damages not previously paid or satisfied by any other person or from any other source (1975)
Joint and several liability changes	1981 Act codified doctrine of joint and several liability; amended 1986	A party who is allocated less than 50% of the total fault may not be jointly liable for more than twice the percentage of fault allocated to that party (1986); joint and several liability eliminated as of March 9, 1989	Joint liability eliminated in cases where party's negligence is 50% or less of total; that person severally liable only (1987)	Repeal of joint and several liability (1987)
Periodic payment of damages	Future damages in excess of $100,000 may be paid periodically; however, noneconomic damages must be paid at outset (1986)	Medical malpractice statute that court may enforce a detailed payment structure enacted (1976); generic statute enacted (1986)		Either party may elect to have future damages over $100,000 paid in periodic payments (1987)
Punitive damage limits		May not be awarded unless supported by clear and convincing evidence (1986)	Awarded only where actual fraud or malice; no dollar limit (1987)	Special court hearing before filing to determine if claim for punitive damages is warranted (1987)
Aimed at Plaintiffs' Difficulty (or Costs) of Winning				
Advance payment	Advance payment not admissible before judgment; jury cannot draw inference of liability therefrom (1976)	Advance payment not admissible; jury cannot draw inference of liability; excess payments not refundable to defendant (1976)	Advance payment not admissible; jury cannot draw inference of liability; excess payments not refundable to defendant (1973)	
Informed consent limits		Patient must show physician has failed to disclose common risks and reasonable alternatives of proposed intervention (1976)		Standard of disclosure set by professional custom; person who in good faith receives consent to a procedure is immune from liability (1975)
Professional standard of care reasserted	Injury must result from failure to follow accepted standard of care (1976)	Professional standard of care applied to all medical services (1976)		Professional standard of care applied to all medical services, emergency department services, generalists, and specialists (1976)
Res ipsa loquitur restrictions		Doctrine prohibited; no presumption of negligence in medical malpractice because injury alone does not imply presence of negligence (1967, amended 1976)		
Statute of frauds for medical promises		No claim against health care provider for breach of oral contract to cure or achieve specific result (1976)		
Miscellaneous				
Extension of "Good Samaritan" statutes		Enacted 1974; amended to cover any person responding to emergency (1976, 1978, 1986)		No liability for refraining from helping in an emergency situation (1973)
Other	Limited liability for nonprofit officials (1986)			

TABLE 3.—*Physicians' Obstetrical Practice Patterns in Four WAMI States by Specialty*

State (Year of Survey) and Specialty	Percent Doing Obstetrics	Respondents, No.
Washington (1989)		
FP/GP	46	1,002
Ob/Gyn	80	359
Alaska (1988)		
FP/GP	37	141
Ob/Gyn	76	37
Montana (1988)		
FP/GP	48	130
Ob/Gyn	95	37
Idaho (1989)		
FP/GP	53	249
Ob/Gyn	96	54

FP/GP = family and general practice, Ob/Gyn = obstetrics and gynecology

of obstetricians continue to practice obstetrics, ranging from 96% in Idaho to 76% in Alaska. We know from earlier studies that the number and proportion of family physicians practicing obstetrics have declined in all four states.[9-11,15]

The propensity to practice obstetrics differs notably from rural to urban areas, as seen in Table 4. In every state, rural family physicians are much more likely than their urban counterparts to practice obstetrics. In all four states, most rural family physicians practice obstetrics, and most urban family physicians do not.

Although obstetricians follow the same pattern, the distinction between urban and rural practitioners is much less pronounced. The only state in which a substantial number of obstetricians no longer practice obstetrics is Washington, where 70 urban obstetricians who responded to our survey reported that they had given up obstetrics. This number exceeds the total of all other obstetricians in the four states who report they no longer practice obstetrics.

In addition to women living in rural areas, the other major population segment affected by the decline in the availability of obstetric practitioners has been the medically indigent, represented in this study by patients enrolled in the Medicaid program. Table 5 shows the policies adopted by active obstetric practitioners in three of the four states toward Medicaid-supported women as reported on the surveys. Although data were unavailable for Montana, the returns from the three other states show a pattern considerably more disparate than was seen with respect to the decision to practice obstetrics at all. In all three states, family physicians reported that they are more likely than obstetricians to accept an unlimited number of Medicaid patients. In Alaska, however, by far most of both types of providers stated that they will take all Medicaid patients, a decision opposite to that in Washington and Idaho. In these two states, most physicians limit the number of Medicaid patients they will accept. Few practitioners in any location responded that they provide no care to Medicaid women.

Discussion

There are many similarities across the four states in this study, with respect to both problems of obstetric access and the legislative responses to these problems. Although these are cross-sectional data, we know from anecdotal information and previous studies that before the past five years most family physicians—and virtually all obstetricians—incorporated obstetrics into their practices.[16] Yet this study shows that a minority of family physicians now continue to actively practice obstetrics, particularly in urban areas. Given the dependence of rural communities on family physicians for routine obstetric care, this pattern explains the widespread concern about the availability of that care in these states.

The data are remarkably similar for the four states. As in other studies, physicians reported that issues related to medical malpractice are the most powerful factors influencing their collective decisions to continue basic practice.[2,15] The cost of medical malpractice insurance is the most important factor, often exceeding the fiscal capacity of family physicians, who usually have relatively few obstetric patients, to continue to offer this service. To this economic decision is added the difficult-to-quantify—but no less important—emotional effects of a climate in which obstetric malpractice suits are perceived as increasingly common and increasingly expensive.

These data also suggest that there may be problems in ensuring that medically indigent persons receive ready access to obstetric care. Although substantial differences exist among the three states for which we have data, most of the physicians in these surveys ration care to medically indigent persons, a finding similar to that of other studies.[8] The impression from these surveys is that the care of medically indigent patients tends to fall on the shoulders of a subset of the physician population. If these relatively few physicians make the decision to quit practicing obstetrics, the availabil-

TABLE 4.—*Percentage of Physicians Currently Practicing Obstetrics by Specialty and by Urban or Rural Designation in Four WAMI States*

State (Year of Survey) and Specialty	Percent Doing Obstetrics		Respondents, No.	
	Rural	Urban	Rural	Urban
Washington (1989)				
FP/GP	64	43	845	154
Ob/Gyn	95	79	334	22
Alaska (1988)				
FP/GP	51	18	60	81
Ob/Gyn	83	72	25	12
Montana (1988)				
FP/GP	54	17	12	123
Ob/Gyn	96	100	14	24
Idaho (1989)				
FP/GP	57	35	40	208
Ob/Gyn	97	94	16	38

FP/GP = family and general practice, Ob/Gyn = obstetrics and gynecology

TABLE 5.—*Current Policy Toward Medicaid Patients by Obstetric Physicians in 3 WAMI States**

State (Year of Survey) and Specialty	Physicians, %			No. of Respondents
	Unlimited No. of Medicaid Patients	No Care to Medicaid Patients	Limit No. of Medicaid Patients	
Washington (1989)				
FP/GP	34	7	59	442
Ob/Gyn	21	8	71	273
Alaska (1988)				
FP/GP	85	10	5	52
Ob/Gyn	79	14	7	28
Idaho (1989)				
FP/GP	45	12	43	120
Ob/Gyn	30	10	60	50

FP/GP = family and general practice, Ob/Gyn = obstetrics and gynecology

*Based on physicians' own estimates.

ity of obstetric care to this vulnerable part of the population may decrease rapidly and possibly catastrophically.

Although we do not attempt to link the declining availability of obstetric practitioners directly with legislative modifications of tort and insurance law, the review of legislation shows that all four states enacted "strong" tort reforms at about the same time that declining obstetric care availability became a major political issue in the Pacific Northwest and Alaska. The reforms are remarkably similar across all four states, relying for the most part on legislative changes designed to make it more difficult for plaintiffs to prevail and less lucrative when they do win a jury verdict.

The similarity of the legislative changes makes it difficult to link any particular legislative strategy with any particular effect on provider behavior. It is clear from these surveys that a substantial number of obstetrically trained physicians remain outside the obstetric work force. Other sources of information make it evident that all four states still consider themselves to be in the midst of a crisis of obstetric availability, largely due to the reluctance of providers to either practice obstetrics at all or provide it to certain segments of the population.

Should we conclude from these data that tort reform has been a failure? Or has the concern over medical malpractice issues been a red herring, invoked by physicians who choose to discontinue obstetric practice for unrelated reasons that they are less willing to disclose? Although both of these hypotheses may ultimately prove to have some merit, it is too early to conclude that tort reform has not succeeded.

The insurance cycle in medical malpractice is relatively long and is affected not only by the legal fabric but by the investment climate. The cost of medical malpractice insurance is affected only in part by the prevailing laws, and changes in law may require many years before they will affect the reserve and premium responses of insurance companies.

In addition, the modification in tort law may have prevented an even more pervasive crisis. Anecdotal reports suggest that, at least in Washington State, there has been some stabilization of provider supply, and this may be the case in the other states as well.[14] The enactment of California's Medical Insurance Compensation Reform Act—first passed in 1975 and ruled constitutional in 1985—has been credited by that state's medical underwriters as the primary reason that medical malpractice premiums have moderated in that state.[17] Changes in tort law are probably less likely to affect current practitioners—who may be reluctant to attempt to return to practicing obstetrics after a hiatus of several years—than future practitioners. Thus, we will need more time to draw firm conclusions.

The four WAMI states have confronted similar problems and have responded to these problems in a similar way. These data suggest that there may be some value in adopting a regional approach to the resolution of these issues. Certainly, pooling data about obstetric practice, legislative changes, and medical malpractice experience seems to have value for all the states. Given the fact that many of the problems are shared, it is likely that solutions will also be effective beyond the borders of individual northwestern states.

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